

Public Safety Official Use Only
Patient Contact # _____

**PATIENT CONTACT INFORMATION
FOR
SUSPECTED MEDICAL EXPOSURE**

Your Name: _____ Age: _____ Sex (M or F): _____

Address: _____
Number Street Apt./Suite #

_____ City State Zip Code

Day Phone: (____) _____ (Home/Work) Night Phone: (____) _____ (Home/Work)

Cellular Phone: (____) _____ Pager: (____) _____ PIN _____

Fax Phone: (____) _____

Contact Person (not living at same address): _____ Phone: _____

Were other family members with you at time of exposure (Yes / No)? If Yes:

Name: _____	Age: _____	Sex (M or F): _____
Name: _____	Age: _____	Sex (M or F): _____
Name: _____	Age: _____	Sex (M or F): _____
Name: _____	Age: _____	Sex (M or F): _____

Your location at the time of initial exposure notification (be specific, e.g., northwest corner of the second floor near customer service...): _____

Approximate amount of time you were in the exposure area (be specific, e.g., work shift started at 8:00 am, and exposure notification came at approximately 10:45 am. Approximate total time in exposure area was 2:45 hours...): _____

This information will be kept confidential, and will only be utilized by Public Health officials to facilitate contacting you with follow-up information. Thank you for your cooperation.

PATIENT DISPOSITION (To be completed by Public Safety Officials)

Has patient been decontaminated at the scene? Y /

If Yes, status of patient's clothing and personal effects:

☐ Decontaminated ☐ Retained by HIRT ☐ Released to Patient

If No, is patient electing to leave the scene and declining this service? Y / N

II. Has patient been provided with pertinent medical information? Y / N

III. Has patient been transported to a medical facility?

If Yes, which facility: _____

IV. Comments: